

Y.A.L.E. School

Consent for Administration of Acetaminophen and Ibuprofen

School Year 2023-2024

Name: _____

Date of Birth: _____

I give permission for my child, _____, to receive Acetaminophen and/or Ibuprofen as initialed below on this form if deemed necessary by the Registered Nurse/School Nurse. Dosage will be calculated by the dose recommendations already labeled on the medication according to the child's weight and age. I understand that generic equivalent medications may be used. Please note: if you would like to have any other medications administered to your child, the Consent for Administration for Prescribed Medication must be completed and signed by parent/guardian and a health care provider.

GRADE K-5

Acetaminophen (Tylenol) and Ibuprofen (Motrin) per manufacturer's directions for child's weight and age, every 4 hours, as needed, for headaches, burns, earaches, muscle aches, brace pain and menstrual cramps.

Middle School – Grade 6-8 and High School – Grade 9-12

Acetaminophen (2) 325 mg tabs or Ibuprofen (2) 200 mg every 4 hours, as needed for headaches, burns, earaches, muscle aches, brace pain and menstrual cramps.

I understand that the medication I have checked will be administered by the Registered Nurse/School Nurse in accordance with established protocols developed by the School Physician.

Yes or No (Circle one). I would like Acetaminophen (Tylenol) administered to my child as needed for headache, burns, earache, muscle aches, pain, and menstrual cramps.

Yes or No (Circle one). I would like ibuprofen (Motrin) administered to my child as needed for headache, burns, earache, muscle aches, pain and menstrual cramps.

Yes or No (Circle one). My child can swallow pills.

****PARENTS, PLEASE PROVIDE AND DELIVER CHEWABLE AND LIQUID MEDICATION****

Parent/Guardian Signature _____ Date _____

SIGNATURE REQUIRED